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WHY CONTINUING MEDICAL EDUCATION? *

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I PRESENT this paper with mixed feelings. There can be no question of the compliment implied by an invitation to appear on this program and I am human enough to feel a glow of satisfaction in having been asked. However, I am not optimistic about the usefulness of gatherings which merely place before an audience a group of speakers, particularly a group whose views are generally predictable from what they have already said and written about continuing education. Some of us have been saying essentially the same things for at least a decade; I sometimes wonder whether anyone listens. For, despite a seemingly endless round of conferences, symposia, round-table discussions, and panel debates over the last 20 years, continuing medical education in 1974 is not greatly different from what it was in 1964—or in 1954 for that matter. There is simply a greater quantity of the same familiar things.

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In light of that experience, perhaps our time might be better spent if we adjourned now to enjoy the special show at the Guggenheim Museum or simply to wander aimlessly through the park, absorbing the sun and enjoying the magnificent fall colors. I am not making such a proposal only because I also have the feeling that we may be on the edge of a major advance in continuing education. If this meeting can lead us one step closer to a significant change in our lives as physician-teachers and learners I am fully prepared to spend this day and many more in trying to bring it about.

I have been asked to begin our deliberations by responding to the query "Why continuing medical education—what are the objectives and the indications of need?" One could dismiss these as frivolous questions whose answers are too obvious to require serious discussion. I prefer, instead, to deal with them as the organizers of this program probably intended: as the basic issues for which rational answers must be provided before we can address the mechanisms for carrying out the mission of continuing education.

But there is the rub—rational answers. Continuing education, like basic and graduate education in medicine, has rarely been characterized by rationality so much as by rationalization. We can always find some persuasive reason for doing what we want to do; we may even convince a substantial number of others that what we want is right. Yet in moments of private reflection such as those that I suggested we might have in a nearby park, even the most vigorous protagonists of currently fashionable modes of programming must suffer some doubt about the utility of what they espouse so vigorously in public.

Why continuing medical education? Three generalizations keep recurring in the literature. We say first that it is the personal responsibility of a professional to engage in never-ending refinement of his professional competence; second, that the body of biomedical knowledge is changing so rapidly that each of us must struggle constantly simply to keep up with an increasingly narrow field since it is hopeless to try to keep abreast of general medical knowledge; and third, that many deficiencies in health care not only exist but could be corrected by the appropriate continuing education of practitioners—particularly those practitioners who do not take part in programs of continuing education.

Let us examine these three elements in reverse order, beginning with the question of what deficiencies in health care need improvement. Despite its logical appeal, the thought that educational diagnosis should precede educational therapy is relatively new to medical educators and represents one of the most significant contemporary efforts to accomplish substantive improvement in the quality of our educational activities. It is the subject that will occupy most of our attention at this meeting and I am confident that we shall be reminded again of the elegant methods now available to identify educational needs—methods that are becoming operational in an increasing number of hospitals. At the same time we are all familiar with the cries of pain which have accompanied the development of these diagnostic data-gathering systems and the resistance, both active and passive, to educational exploitation of the findings in the interest of further improving the care of patients. Physicians are not eager to expose their hospital work to others and a practitioner's office is, with a few significant exceptions, still virtually impregnable. Like the teacher's classroom, it is his castle, subject to external scrutiny only rarely and only by special arrangement.

But even the hospitals to which most attention has been directed in this campaign are community hospitals and the physicians are largely independent practitioners. It would be wiser educationally to begin this systematic scrutiny at the other end of the spectrum, subjecting to intensive study the methods of patient care which are practiced *in* university hospitals and *by* the full-time faculty. Such a model would be far more persuasive in convincing others of our commitment to educational diagnosis than all our words about the importance of audits and peer review elsewhere in the system. Despite the claims of professors—claims that are sometimes distinguished more by their arrogance than by anything else, all is not well in the towers of academe. Duff and Hollingshead have received much abuse for what they published about one such center,* but their findings have not yet been refuted convincingly. Even though they were more objective in their descriptions than the colorful writers of the daily press, the response of the academic community to both kinds of reports more often suggests cover-up or dismissal than a thoughtful consideration of the issues.

*Duff, R. S. and Hollingshead, A. B.: *Sickness and Society.* New York, Harper and Row, 1968.

The diagnosis of deficiencies in the care of patients is surely an indispensable strategy, but far more difficult is the successful translation of even distasteful findings into sound educational practices that have some hope of alleviating the shortcomings which are identified. As a profession we seem more willing to consider or even to adopt new information or new technology than to change in any fundamental fashion the way we use ourselves. We are convinced, or so the literature of continuing education would make us seem, that it is our failure to apply new knowledge that represents the weakest link in the chain of assuring that the highest quality of medical care is delivered by the greatest number of physicians to the largest number of patients. While this view may be correct, I am not familiar with any solid data to support it. In fact, the correction of the major health problems in the United States, as in other parts of the world, does not appear to require any substantial body of new knowledge. Rather, it requires that physicians use the knowledge they already have in a different way or more fully exhibit the professional attitudes that have characterized the physician's role for as long as there have been physicians. As a more eloquent speaker than I recently said, "If I were asked to compose an epitaph on medicine throughout the 20th Century, it would read: 'Brilliant in its discoveries, superb in its technological breakthroughs, but woefully inept in its application to those most in need. . . .' "*

Since I was a medical student 30 years ago, I have heard and I have read in medical literature covering a far longer period that physicians can be of the greatest service to society if they work at preventing disease rather than treating it. But which gets more academic attention and reward: the replacement of damaged arteries and heart valves or the prevention of smoking and obesity? We have been told again and again that most of those who consult us are the anxious well rather than the curable sick. But which gets more attention in our educational programs—the pharmacologic action of drugs and their side effects or the skill of listening and providing reassurance? Studies of the compliance of patients have revealed repeatedly a high level of failure to follow physicians' instructions and even a widespread failure to have prescriptions filled. But our educational programs seem far more

*Professor Rex Fendall, quoted by H. E. Majid Rahnema at the *Seminar on Health Services Development.* Teheran University, Teheran, Iran, March 6, 1974.

often to deal with what is new in the therapeutic armamentarium than with ensuring that either old or new treatments are used by patients in the manner recommended by their doctors.

I am afraid that most of us have been seduced by the notion that the professional responsibility which I cited as a primary reason for continuing education is a responsibility to keep abreast of current information even if the information may have little use to many patients and even if it means diverting attention from other elements of professional competence that may be of far greater importance to those we serve. Having been convinced that "keeping up" is the goal, we are then easily led to the conclusion that the need in continuing education is for more instruction: for example, 3,677 accredited courses were offered in the 1974-1975 academic year, compared to less than half that number 10 years earlier.* If practitioners will not voluntarily attend these courses, then there is a growing feeling that they must be coerced to do so by making participation a requirement for staff privileges, membership in professional societies, or even relicensure. It is easy to understand the worthy motives behind these actions, even while crying out against the methods themselves.

If professional responsibility means fulfilling a social obligation to provide a professional service, then the objective of continuing education should be to ensure the maintenance of that competence which will provide what most patients need, not to guarantee that physicians will know how to deal with things they may never encounter, nor even that they will comply with a predetermined set of procedures which allow no opportunity for the exercise of professional judgment.

If you agree with the goal I have cited for meeting the needs I have outlined, then programs of continuing education very different from those most prominent today must be adopted. But it is unlikely that these programs will be adopted unless the attitudes which underlie personal responsibility for learning are implanted in physicians at the beginning of their professional education and nurtured throughout its course—not merely imposed at its conclusion. This will require teachers who play a very different role from that commonly encountered today. Such teachers will focus the attention of students first upon the process of inquiry into problems rather than upon the acquisition of facts about problems; they will be more concerned with

*Continuing education courses for physicians. *J.A.M.A.* (Suppl.) *229*:886, 1974.

exploring issues with students than with providing those students with answers to questions they have never recognized; they will be less devoted to assessing the knowledge that students acquire than to determining the ways in which that knowledge is used in fulfilling the professional tasks they face. Such a role requires more listening and less talking by teachers, and that is scarcely the way we most regularly behave, despite our verbal acknowledgement of better instructional methods. As Dickinson W. Richards said many years ago:

> For our students we have cast the lecture into outer darkness as an outworn remnant of an earlier pedagogic era; but for ourselves, we teachers continue to lecture to each other almost incessantly. We dart all around the country . . . winter and summer, spring and fall, leaving our appointed tasks—such as teaching students—and when we get there what do we do? We sit down and listen to lectures, or worse still we stand up and give them.

Regrettably, a recently completed survey by the World Health Organization of continuing education in member nations has shown that the lecture is still the most widely used instructional method by a large margin.

And so you may understand the cause for my initial pessimism when even at such programs on continuing education as this one the plan calls for the individual delivery of information for more than four hours and the joint pursuit of questions for only 40 minutes. I have little hope that many of us will be changed significantly by what we hear today, although some of us may leave better informed than when we arrived. But if change in behavior is the goal of continuing education, whether it is offered to practitioners or to medical educators, then perhaps most of what we now do must be dismissed in much the same way as Oliver Wendell Holmes, the autocrat of the breakfast table and one-time dean of the Harvard Medical School, once dismissed another component of medicine when he said: "I firmly believe that if the whole materia medica as now used could be sunk to the bottom of the sea it would be all the better for mankind—and all the worse for the fishes."

I leave you with the suggestion that it is time for us to start anew with continuing medical education also.